For help in your community call:

Washington State Department of Social & Health Services

Washington Apple Health for Kids

Application For Children's Medical Benefits

This application is for medical coverage only for children and teens under 19. Anyone can apply on behalf of a child. Children may apply on their own behalf. **We will send the person listed in box 1 all follow-up information.** If you have questions or would like help filling out this form, just call 1-877-543-7669. We'll be happy to help you!

Please print in black or blue ink. Do not use pencil. **(List parent, guardian or contact person who will receive follow-up information)**

1 FIRST NAME | MIDDLE INITIAL | LAST NAME

2 ADDRESS WHERE YOU LIVE | STREET | CITY | STATE | ZIP CODE

3 MAILING ADDRESS (IF DIFFERENT) | STREET | CITY | STATE | ZIP CODE

4 TELEPHONE NUMBERS

HOME ( )

WORK ( )

MESSAGE ( )

5 Do you have trouble speaking, reading or writing English? Yes ☐ No ☐

What language or alternative format do you need? _____

Do you need an interpreter? (If yes, we will help you through an interpreter.) Yes ☐ No ☐

What language do you speak? _____

6 Does a child under 19 have a medical condition that needs attention right away? Yes ☐ No ☐

Is anyone in your home pregnant? Yes ☐ No ☐

If "yes," who? _____

General Information

7 List family members **living together**.
(If needed, attach a separate sheet of paper to list more family members.)

NAME (FIRST, MIDDLE, LAST)	SEX M or F	RELATION TO YOU	BIRTH DATE (MO/DA/YR)	SOCIAL SECURITY NUMBER * = OPTIONAL	U.S. CITIZEN YES NO	PLACE OF BIRTH (CITY/STATE)	COMPLETE IF CHILD IS **NOT** A U.S. CITIZEN: LIST DATE CHILD ARRIVED IN U.S.	COMPLETE IF CHILD IS **NOT** A U.S. CITIZEN: DOES CHILD HAVE A SPONSOR? YES NO
A. PARENT, GUARDIAN OR SELF				*	☐ ☐			
B. SPOUSE OR OTHER PARENT (if living in the home)				*	☐ ☐			
C. LIST CHILDREN & TEENS UNDER 19 YEARS OF AGE **(who want medical benefits)**					☐ ☐			☐ ☐
D.					☐ ☐			☐ ☐
E.					☐ ☐			☐ ☐
F.					☐ ☐			☐ ☐
G. LIST OTHER ADULTS/CHILDREN IN THE HOME **(who do not want medical benefits)**				*		Note: Please attach any documents showing children's status.		
				*				

8 Is a child under age 19 in your household disabled? Yes ☐ No ☐

If "Yes," who? _____

Expenses This information can help your children qualify.

9 Do you pay for childcare while you work? Yes ☐ No ☐ If "Yes," how much per month? $_____

Do you pay someone to take care of a disabled dependent adult while you work? Yes ☐ No ☐ If "Yes," how much per month? $_____

10 Do you pay court ordered child support for a child who is not living in your home? Yes ☐ No ☐ If "Yes," how much per month? $_____

Income Enter GROSS pay (before taxes or expenses).

(Please attach proof of income for last 30 days)

11 PARENT'S EMPLOYER NAME AND PHONE

( )

12 Amount you received in the last 30 days before taxes or expenses were taken out:

$_____

How much of this income is from self employment?*

$_____

13 SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME AND PHONE NUMBER:

( )

14 Amount your spouse (or other parent living in the home) received in the last 30 days before taxes or expenses were taken out:

$_____

How much of this income is from self employment?*

$_____

*IF YOU OR YOUR SPOUSE (OR OTHER PARENT LIVING IN THE HOME) ARE SELF-EMPLOYED, YOU MAY GET OTHER DEDUCTIONS. PLEASE CALL 1-877-KIDS-NOW FOR MORE INFORMATION OR APPLICATION ASSISTANCE.

	OTHER HOUSEHOLD INCOME	AMOUNT RECEIVED IN LAST 30 DAYS	WHICH FAMILY MEMBER EARNS THIS INCOME?
15	CHILD SUPPORT	$	
16	ALIMONY	$	
17	SOCIAL SECURITY PAYMENT	$	
18	UNEMPLOYMENT BENEFITS	$	
19	INVESTMENT INCOME/INTEREST/ DIVIDENDS	$	
20	VETERANS BENEFITS	$	
21	LABOR & INDUSTRIES	$	
22	MILITARY ALLOTMENTS	$	
23	OTHER (Please explain)	$	

24 Do you need help paying for unpaid medical bills – within the last 3 months – for any of the children you are applying for? Yes ☐ No ☐

If "Yes," please send copies of all household income for the months you would like us to review.

Health Insurance Information Tell us about any health insurance your **children** already have.

25 A Do any of the **children** you are applying for already have health insurance? Yes ☐ No ☐

25 B If "Yes," does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services? Yes ☐ No ☐

26 A Have your **children** been covered by job-related health insurance in the last 4 months? Yes ☐ No ☐

26 B If "Yes," did the premium cost less than $50 per month for dependents? Yes ☐ No ☐

27 If you checked "Yes" to any of the above questions (25 a or b or 26 a or b), please list the name of the insurance company or employer providing health insurance for your children.

INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER (OPTIONAL)

Children's Race/Ethnic Background (Voluntary Information)

We ask you to voluntarily tell us your children's race or ethnic background. This information will not be used in considering your eligibility for benefits.

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other _____

Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origian, religion, age, sex or disability.

Read Carefully Before Signing

This application is for medical benefits for children only. If anyone in your family already receives, or would like to apply for cash benefits, basic food or other benefits, please contact your local DSHS Community Services Office (CSO).

- DSHS may ask you to prove the information you are giving them to tell if you are eligible. You can ask DSHS for help in getting proof.
- Your information may be reviewed by other state or federal agencies. This information will NOT be shared with Immigration and Naturalization Service (INS).
- By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care.
- DSHS may share your child's immunization history with the Child Profile Immunization Tracking System.

DECLARATION AND SIGNATURE
I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Signature of Applicant

X _____ _____
Date

How to Submit

MAIL TO:

Dept. of Social and Health Services
P.O. Box 45531
Olympia, WA 98504-5531

FOR HELP:

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